DETERMINATION OF DISABILITY
Medical Information

State Form 1380 (R9 / 11-00) / OMPP 0251A

Prescribed by the Indiana Family and Social Services Administration, Division of Family and Children

Return form in the attached envelope to _____ County Office,

Division of Family and Children. Address:_____.

CONFIDENTIALITY STATEMENT

The personal information requested on this form will be used in the determination of your entitlement to or continued receipt of Medical Assistance administered by the Indiana Family and Social Services Administration. Disclosure of the information requested is mandatory pursuant to the provisions of IC 12-15 -1-1 *et seq.* Non-disclosure of the information requested will hamper and possibly prevent the delivery of assistance to you. All personal information collected on this form will be treated as confidential pursuant to 470 IAC 1-2-7 and 470 IAC 1-3-1.

NOTICE TO EXAMINING PHYSICIAN

By court order and federal regulation, if the client appeals the decision of the State Medicaid Medical Review Team, this medical information becomes available to the client or his/her legal representative.

DETERMINATION OF DISABILITY: Medical Information

Indiana Law [IC 12-14-15-1(2)] requires that, in order to be eligible for Medical Assistance to the Disabled, a person must have a physical or mental impairment, disease, or loss which appears reasonably certain to result in death or that has lasted or appears reasonably certain to last for a continuous period of at least four (4) years without significant improvement and which substantially impairs his/her ability to perform labor or services or to engage in a useful occupation. This is not the same definition of disability that is used by the Social Security Administration, or other agencies.

The law (IC 12-14-15-1 (2) and IC 25-22-5) requires an individual to be examined by a physician holding an unlimited license to practice medicine.

The Medicaid Medical Review Team will make the final disability determination.

SECTION I - IDENTIFICATION *(to be completed by County Office, Division of Family and Children)*

Name *(first, middle, last)*			Case number *(type, code, serial)*
Address *(street address or Rural Route number)*			City
Date of birth *(month, day, year)*	Sex	Race	Marital status

SECTION II - AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Signature of applicant or guardian	Date signed *(month, day, year)*

Case number

SECTION III - REPORT OF MEDICAL EXAMINATION

Complete only those sections pertinent to a description of substantial impairment.

A. Current Medical History *(Include the patient's complete medical history for at least 12 months. Attach additional sheets if necessary)*

How long has the patient been treated by you?

Please list all diagnostic tests and/or evaluations performed on the patient and their results.

Please list all treatments performed to-date relative to his / her impairment(s)

What are the patient's current medications including dosage and frequency?

Is the patient compliant with medications and treatment? If No, please explain.

Case number

B. Current Medical Evidence

Height	Weight	Urinalysis	Sugar	Albumin

Fasting blood sugar test *(required if diagnosis is diabetes)*

Blood data *(CBC if available)*

Eyes *(degree of impairment of vision, if any)*

OS _____

OD _____

Ears *(degree of impairment of hearing, if any)*

AS _____

AD _____

Nose, throat, mouth *(describe abnormalities)*

Neck and lymphatic system *(describe abnormalities)*

Cardiovascular System

Blood Pressure	Systolic	Diastolic	Pulse rate	Cardiac enlargement?	If Yes, degree
				☐ Yes ☐ No	

Murmurs?	Rhythm	Degree of decompensation	Is there auricular fibrillation?
☐ Yes ☐ No			☐ Yes ☐ No

Ever on digitalis?	If Yes, when?	Angina pectoris?
☐ Yes ☐ No		☐ Yes ☐ No

Evidence of past myocardial infarction?	If Yes, date occurred
☐ Yes ☐ No	

Ever on antihypertensive drugs?	If Yes, when?	Response
☐ Yes ☐ No		

Dyspnea?	Cyanosis?	Edema?	Type of heart disease *(please use A.H.A. classification)*
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

If cardiac disease, attach current EKG, treadmill, catheterization or other interpretations.

	Condition of palpable arteries	Varicosities

Chest: Normal? ☐ Yes ☐ No *If No, complete the rest of this section.*

Describe abnormalities

Asthma?	Frequency of attacks	Severity	Medication
☐ Yes ☐ No	☐ Daily ☐ Monthly		

Tuberculosis?	Active	Arrested	Pulmonary obstructive disease?
☐ Yes ☐ No			☐ Yes ☐ No

If chest disease, describe and attach current x-ray report

If emphysematous, send pulmonary function test results.

Case number

Nervous System: *If the disability determination is to be based upon any of the following, enter a brief explanation of the degree of deterioration and attach appropriate evidence.*

Organic *(describe senility, tremors, atrophy, speech problems, gait, paralysis, epilepsy)*

Non-Organic *(describe evidence of psychosis or other mental disorder, including functional restrictions of daily activities and interests, the deterioration in personal habits and ability to relate to other persons)*

Please indicate whether you recommend a psychological/psychiatric mental status evaluation ☐ Yes ☐ No

If Yes, briefly state the reason(s) for your recommendation, including a description of mental status, defects or problems (*if applicable*)

Mental Deficiency: *This section must be completed if there is a diagnosis of mental retardation.*

Full scale I.Q.	Or estimated mental age	Is the patient mentally capable of handling his/her own affairs? ☐ Yes ☐ No

Musculo - Skeletal System: Bones, joints and extremities normal? ☐ Yes ☐ No

If No. describe disease, defect or injury and state limitation of motion. Attach x-ray report, if available

Arthritis? ☐ Yes ☐ No	Type

Describe deformities

Case number

Neoplasms: ☐ Yes ☐ No

Site		Metastasis?
	☐ Benign ☐ Malignant	☐ Yes ☐ No

If Yes to Metastasis, location *(explain)* - Please give clinical stage, if known.

Abdomen:

Describe abnormalities

Hernia?	Describe
☐ Yes ☐ No	

Genito - Urinary: *(describe abnormalities)*

Gynecological: *(describe abnormalities)*

Ano - Rectal: *(describe abnormalities)*

SECTION IV - DIAGNOSIS / PROGNOSIS

1. *List below the patient's present diagnoses and your prognosis after treatment, of each disorder. Indicate if the disorder can be controlled, resolved, or improved by treatment.* ***PLEASE INDICATE PRIME DIAGNOSIS(ES) FIRST.***

Diagnosis	Date Began	Date Condition Began Affecting Ability To Perform Labor/Services	Prognosis After Treatment
A. PRIME:			
B. PRIME:			
C. SECONDARY:			
D. SECONDARY:			
E. SECONDARY:			

Case number

2. Does the patient's impairment(s), taken together or individually, currently affect his/her ability to perform labor or services or engage in a useful occupation? If so, is the patient's inability to work temporary or is it likely to continue? What is the basis for this conclusion?

3. Is additional consultation or diagnostic evaluation / testing necessary to clarify the degree of impairment? If so, please specify the type of consult / exam / test required. Additional testing / exams may only be performed if prior-authorized by the Medicaid Medical Review Team physician. In order to request prior authorization, please call (317) 232-2028. For additional information, please refer to the attached OMPP 0251 cover sheet.

4. What are the standard treatment options to correct, improve or control the patient's condition(s)?

Do medical reasons prevent standard treatment options? *(If Yes, please explain)*

☐ Yes ☐ No

Is it expected that the patient's functional limitations will improve with regular medical care and / or the treatment options listed above?

☐ Yes ☐ No

a. If the functional limitations **will improve**, please explain:

How will they improve?

Are they expected to improve enough to enable the person to participate in gainful employment?

☐ Yes ☐ No

If Yes, how long is the duration of the limitation expected to last before the patient can be employed?

☐ 0-under 1 year ☐ 1-2 years ☐ 3-4 years ☐ greater than 4 years

b. If the functional limitations are **not expected to improve**, please explain:

Why will they not improve?

Are the limitations substantial enough to prevent the patient from participating in his / her usual occupation?

☐ Yes ☐ No

Are the limitations substantial enough to prevent the patient from engaging in any type of gainful employment?

☐ Yes ☐ No

Case number

5. Capacity and Limitations

Can the patient currently carry out normal activities? ☐ Yes ☐ No

If No, specify, using the list below, how his/her condition affects activities or mobility by checking off the degree of severity as either not significant, moderate or significant. Please indicate in column 4 below whether the limitations are expected to continue even after regular medical care and / or treatment options as listed in Question 4 have been explored.

LIMITATIONS

ACTIVITY	NOT SIGNIFICANT	MODERATE	SIGNIFICANT	WILL LIMITATION CONTINUE AFTER TREATMENT?	
				YES	NO
Sitting	☐	☐	☐		
Standing	☐	☐	☐		
Walking	☐	☐	☐		
Lifting	☐	☐	☐		
Grasping / Manipulation	☐	☐	☐		
Pushing / Pulling	☐	☐	☐		
Bending	☐	☐	☐		
Squatting	☐	☐	☐		
Crawling	☐	☐	☐		
Climbing	☐	☐	☐		
Reaching Above Shoulders	☐	☐	☐		
Being Around Machinery	☐	☐	☐		
Driving	☐	☐	☐		
Repetitive Leg Movements	☐	☐	☐		
Exposure To Temperature / Humidity Changes	☐	☐	☐		
Exposure To Dust, Fumes or Gases	☐	☐	☐		
Normal Housework	☐	☐	☐		
Caring For Personal Needs	☐	☐	☐		

6. Additional Comments

PHYSICIAN'S CERTIFICATION

* A stamp or the signature of a person other than the examining physician is not acceptable.

I certify that I examined this person on _____.
Date of examination

Signature of examining physician *

Printed or typed name of examining physician

Date signed *(month, day, year)*

Indicate physician specialty